

PATIENT INFORMATION

First Name:	Date of Birth:	Age:
Last Name:	Social Security Number:	
Address:	Home Phone:	
City, State, Zip:	Work Phone:	
Email Address:	Cell Phone:	
	Arizona Phone No.:	

RESPONSIBLE PARTY

First Name of Guarantor:	Patient Relationship to Guarantor:	
Last Name of Guarantor:	Gender:	Marital Status:
Address:	Date of Birth:	
City, State, Zip:	Social Security Number:	
Employer:	Home Phone:	
Employer Address:	Work Phone:	
City, State, Zip:	Cell Phone:	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:	Subscriber Name:
Address:	Date of Birth:
City, States, Zip:	Patient Policy ID:
Plan Phone Number:	Group Number:
Effective Dates:	Patient Relationship to Subscriber:
SECONDARY INSURANCE NAME:	Subscriber Name (Secondary Ins.):
Address:	Date of Birth:
City, State, Zip:	Patient Policy ID:
Plan Phone Number:	Group Number:
Effective Dates:	Patient Relationship to Subscriber:

EMERGENCY CONTACT AND PARENT / LEGAL GUARDIAN INFORMATION

Emergency Contact Name:	Parent/Legal Guardian Name:
Address:	Address:
Patient Relationship to Contact:	Parent Phone Number:
Contact Phone Number:	Parent Work Phone Number:
Contact Work Phone Number:	Parent Cell Phone Number:

MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION

I hereby authorize UCR Health Centers to furnish the insured's insurance company all information which the insurance company may request concerning the patient's present illness or injury. I understand that I am financially responsible to UCR Health Centers for all charges incurred in the course of my treatment at UCR Health Centers and for which the insurance company does not cover, but for which UCR Health Centers is entitled. I hereby authorize UCR Health Centers to provide such medical / surgical care or services as determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by the person signing below.

Signature: _____ Date: _____

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